World Vision Relief & Development, Inc.

WVRD/Mali FY91
FINAL EVALUATION REPORT
KOUTIALA CHILD SURVIVAL PROJECT
REPUBLIC OF MALI

December 1994

Grant No.: PDC-0500-00-1065-00

Beginning Date: October 1, 1991
Ending Date: September 30, 1994

Submitted to:

United States Agency for International Development
Child Survival and Health
Office of Private and Voluntary Cooperation
Bureau for Humanitarian Response

World Vision Mali Contact:

Torrey Olsen
World Vision Mali
(223) 225189

PVO Headquarters Contact:

Larry Casazza, M.D., M.P.H.
World Vision Relief t Development, Inc.
919 West Huntington Drive
Monrovia, CA 91016
Phone: (818) 357-7979
Fax: (818) 358-2896

Prepared by: Dandara Kant&, Consultant
Fanta Macalou, USAID

TABLE OF CONTENTS

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMPPF	Association Malienne pour la Protection et la Promotion de la Famille (Mali's Planned Parenthood Organization)
BCG	Bacillus Calmette-Guerin vaccine
CHW	Community Health Worker
CLD	Comité Local de Développement
CMDT	Compagnie Malienne de D&veloppement du Textiles
CMIE	Centre Medical Inter-Enterprise
CSSP	Child Survival Support Program
CSP	Child Survival Project
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertussis, Tetanus vaccine
EPI	Expanded Program for Immunization
FAA	First Aid Attendant
FP	Family Planning
FVA	Food for Peace and Voluntary Assistance (USAID)
FY	Fiscal Year
HIS	Health Information System
INRSP	Institut National de Recherche en Santé Publique
KAP	Knowledge, Attitudes, Practice
HCH	Maternal and Child Health
MOH	Ministry of Health
MTE	Midterm Evaluation
NGO	Nongovernmental Organization
OPV	Oral Polio Vaccine
ORS/ORT	Oral Rehydration Solution/Therapy
PVO	Private Voluntary Organization
sss	Sugar Salt Solution
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
VA	Village Association
VHC	Village Health Committee
VHV/HW	Village Health Volunteer/Health Worker
VP	Village Pharmacist
WHO	World Health Organization
WV	World Vision
WVRD	World Vision Relief & Development, Inc.

I. INTRODUCTION

A. Project Background

World Vision began in Mali in 1982 in partnership with missions and churches on five community development projects. Its first protocol agreement with the Government of Mali was signed in 1985. In 1987, World Vision was funded by USAID in the amount of $654,000, with matching funds of $400,000 from World Vision United States (WVUS), to implement a child survival project (CSP) in Koutiala, Sikasso Region. The Koutiala CSP was a four-year project which began in October 1987 and ended in September 1991.

The key objective of the Koutiala CSP was to reduce infant and child mortality and morbidity by strengthening primary and preventive health care for mothers and children under six years at the home and village level through the support of mother and child health activities and the expansion of the Ministry of Health's (MOH) primary health care activities in the district of Koutiala.

After the initial four-year period, a three-year extension was approved by the PVO Child Survival Grants Program of USAID FVA/PVC/CSH in Washington, D.C. The extension phase began on October 1, 1991, and ended on September 30, 1994. This extension was proposed in order to ensure sustainable health benefits in the project area. The Koutiala CSP operated in collaboration with the Compagnie Malienne de Developpement du Textiles (CMDT) after signing a protocol with the Malian Ministry of Health (MOH) (see Appendix 3) and an official letter with the CMDT which defined the area of collaboration (Appendix 4).

B. Project Area

The CSP is located in Koutiala District, 350 kilometers by road southeast of Bamako, the capital of Mali. The district is situated on the northeastern part of the third region (Sikasso), to which it belongs. Koutiala shares common borders with the district of Yorosso on the east, the region of Segou on the west and the north, and the district of Sikasso and the republic of Burkina Faso on the south.

The child survival interventions covered 61 villages within the two subdistricts (arrondissements) of Central and M'Pessoba and also included Koutiala Commune. (The list of the villages covered by CSP activities is in Appendix 6.) The project also supported EPI activities in the entire district of Koutiala, which consists of six subdistricts: Koutiala, M'Pessoba, Konseguela, Kouniana, Zangasso, and Molobala.

The project area is rural, except in Koutiala Commune. The people are mostly farmers. Their main cash crop is cotton, and they also raise livestock. Cotton production for export is a very important part of the economy. The Miankas and the Bambaras are the predominant ethnic groups, and both are sedentary. Eighty-three percent of the rural women are illiterate. They are financially dependent and are not decision makers. They get married very early (15-17 years old).

C. Interventions/Activities

1. *Immunization*

From October 1987 to September 1991, the CSP funded the EPI in all of Koutiala district and participated in the program management (distribution, supervision, planning, monitoring), while the financial and material management was assumed by the MOH health center. From October 1991 to September 1994, based on the lessons learned, the project limited its role to social

mobilization (teaching mothers how to identify an incomplete vaccination and to look for services in the project area).

2. *ORT*

This intervention was implemented in two arrondissements (central and M'Pessoba). It was based on the promotion of home-mixed solution (SSS) to the mother, the distribution of ORS sachets to the animatrices and VHC members, and education on the management of diarrhea1 diseases (breastfeeding and nutrition during and after diarrhea, signs of severe cases to be watched for by mothers in order to refer these cases to the health centers).

From October 1987 to September 1991, the activities were carried out in 18 rural health centers and Koutiala commune. From October 1991 to September 1994, the activities were carried out in 61 villages and Koutiala commune. Also, some hygiene/ sanitation activities for preventing diarrhea were added.

3. *Nutrition*

Growth monitoring involved all children O-3 years old, using a WHO growth chart. The project organized nutrition demonstrations (the communities provided the food), gave IEC on vitamin A, promoted gardening in villages with good water supply, and gave education on good weaning practices.

From October 1987 to September 1989, nutritional activities were done by the rural first aid attendants (FAA) and the matrons. Since 1990, the animatrices were involved in the project, first in the commune and then in all the 61 villages by October 1991.

4. *Haternal Care and Family Planning*

The CSP conducted IEC on the advantages of family planning (FP) and modern contraceptive methods. The services were offered at the maternity center of M'Pessoba and in Koutiala (le Centre Medical Inter Enterprise). The project promoted assisted childbirth, prenatal visits, and training of traditional birth attendants (TBAs).

D. Project Strategy

The project strategy can be outlined in four points:

1. Training of Health Agents

This training concerned three levels:

- Nurses and midwives on Maternal and Child Health (MCH), communication techniques (GRAAP), andliteracytraining.
- FAAs and matrons on MCH and communication techniques (GRAAP).
- TBAs, animatrices, and secouristes on MCH, interpersonal communication, and group communication.

Refresher training was done during the supervision visits.

2. Equipping of Health Facilities

The project provided equipment and supplies for FP, prenatal care, and weighing of children to the rural maternity centers and dispensaries in its intervention area.

3. Financing Xncome-Generating Activities (IGAs)

The project set up IGAs in all 61 villages and Koutiala commune. The animatrices were in charge of these activities under an agreement between them and project. (See copy of agreement in Appendix 5.)

The IGAs were planned to be either individual or collective, based on the choice of the village involved. The goal of these activities was to motivate the animatrices and to sustain health activities (paying for supervision costs, for instance).

4. Facilitating Positive Behavior Change for Child Survival

Most of the project activities focused on IEC.

E. Evaluation Team

The evaluation team was composed of the following persons:

1. Mrs. Kante, Dandara M.S. Researcher, Institute for Training and Applied Research Mali, Team Leader
2. Mrs. Macalou, Fanta, Coordinator, Child Survival and Family Planning, USAID Mali
3. Mr. Santara, Yacouba, USAID/PVO
4. Dr. Sanogo, Zié, Regional Health Director representative
5. Ms. Soumano, Anna, World Vision Mali, Bamako

The core evaluation team was supported by:

- Dr. Coulibaly, Daouda, Child Survival Project Coordinator, Koutiala
- Mrs. Dolo, Katy, Maternal Health Coordinator
- Mrs. N'Diaye, Maïmouna, Nutrition Coordinator
- Mr. Dembele, Jean Charles, ORT and EPI Coordinator

F. Evaluation Methodology

The evaluation was carried out following the Final Evaluation Guidelines of the Office of Private and Voluntary Cooperation, Bureau for Humanitarian Response.

The final evaluation used mainly qualitative methodologies. A quantitative analysis was done a month earlier by a team from INRSP. The results of this survey (see Appendix 10) were used to complement and confirm the findings of the evaluation team from the qualitative studies. Some questions not included in the survey questionnaire were added to the qualitative survey. These questions included those on exclusive breastfeeding and the initiation of breastfeeding.

The evaluation methodology included focus group discussions with mothers aged 15 to 45 years with a child under two. One focus group discussion was held in each village visited (a total of six). The field visits were conducted in the following villages: Francebougou, Bana, Wélenguéna I, Wélenguéna II, N'Gania, and Dintiola. In each of these villages, 8 to 15 women participated in the focus group. A moderator led the discussion, while a reporter took notes. The discussions were also recorded by tape-recorder, with the participants' approval.

In addition to the focus group discussions, semi-structured interviews were done with the Koutiala project staff, the village health committee (VHC) members, the village health workers (including animatrices, TBAs, the hygienist/secouriste), the partners from CMDT, the local health office, and women's associations.

II. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

The following table shows accomplishments against objectives, as revised in January 1993 baaed on a recommendation from the Detailed Implementation Plan (DIP) technical review. The table shows accomplishments according to the midterm and final evaluation surveys. Data for some indicators are missing but the narrative following the table provides an indication of the progress made by the project based on information from sources other than the surveys.

Objectives	Accomplishments MTE Survey	Accomplishments Final Evaluation Survey
I. Nutrition		
· 30% of children aged O-3 years will be weighed three times a year.	48%	54%
· 20% of mothers will start food supplementation for their children by the time they are six months old.	100%	73%
· 25% of mothers will know at least two vitamin A-rich foods.	data not available	83%
· 40% of malnourished children aged O-36 months will receive vitamin A supplementation.	51%	data not available
· 20% of lactating mothers will know the importance of eating a balanced diet.	10%	data not available
II ORT		
· 20% of mothers will know the signs of dehydration.	86%	87%
· 30% of mothers will know the proper management of diarrhea.	30%	80%
· 40% of the villages will institute a weekly sanitation day.	60%	data not available

Objectives	Accomplishments MTE Survey	Accomplishments Final Evaluation Survey
III **Maternal Health**		
· 80% of villages without a maternity center will have at least one trained TBA.	100%	100%
· 60% of the matrons will be retrained in maternal health.	56%	data not available
· 50% of WCBA will hear at least one message on family planning,	48%	data not available
· 20% of adults will hear at least one message on AIDS.	data not available	98%
IV **Immunization**		
· 40% of mothers will know the number of contacts needed to have a child fully immunized.	33%	75%
· 40% of mothers will know the importance of TT vaccination.	99%	91%
V **Malaria**		
· 40% of pregnant women will receive a weekly dose of chloroquine.	68%	data not available

From this table, it is apparent that nearly all of the objectives stated in the DIP have been met. Part of the reason for this is that the revised objectives (reflected in the table above) were set rather low. Nevertheless, the results registered by the final evaluation survey demonstrate tremendous progress by the project.

Focus Group Analysis

The analysis of the focus group results confirms the findings of the survey regarding the accomplishments made by the project.

The focus groups covered six villages, three from each arrondissement. The total number of participants was 68, all mothers or pregnant women, as follows: Francebougou- 12 participants, Welenguenant I-12 participants, N'Gania- 9 participants, Welenguena II-8 participants, Bana—15 participants, and Dinthiola-12 participants.

The focus groups revealed that project activities had had a positive impact on women's and particularly on children's health. According to all interviewed women, childhood diseases were reduced due to the implementation of health activities by village animatrices, mainly malaria prevention activities (chemoprophylaxis with chloroquine), growth monitoring, nutrition demonstrations, and ORS preparation. Many women also mentioned the benefits of the hygiene, sanitation, and wells maintenance activities on the general health of communities in the village.

In all villages (except for N'Gania) women attested that the health committee members and animatrices had really committed themselves to the health of communities, mainly that of mothers and children. In N'Gania, however, it was revealed that the VHC members and animatrices performed health activities only during supervision visits by World Vision agents. This was due to poor social mobilization in the village.

Intervention-specific results of the focus group discussions were as follows:

Regarding breastfeeding initiation (infants who are breastfed within the first eight hours after birth), a great majority of women reported breastfeeding their infants within eight hours after birth. Only three women reported giving warm sugar water before providing breast milk.

Concerning exclusive breastfeeding, the majority of women reported giving their infant (less than four months) orange juice, water, or other fluids in addition to breast milk. Even among those who practiced exclusive breastfeeding later, five reported initially giving the infant millet flour juice ('kanifing"), a product supposed to open the path of the throat to the breast milk according to cultural beliefs.

- The majority of women reported continuing breastfeeding their children for 20 to 24 months, in addition to giving semi-solid and solid foods.

- In relation to diarrhea management, all women knew that a child with diarrhea should be given ORT. But generally they refer cases of diarrhea to animatrices or health committee members for SSS preparation (this was confirmed by the results of the final evaluation survey), even though all of them had attended SSS preparation sessions and therefore were supposed to have known how to prepare it. It is assumed that mothers refer to the animatrices because they are convinced the latter know better than themselves how to prepare SSS.

  As related to giving continued fluids to children with diarrhea, all women without exception said that they continued breastfeeding, but three women didn't give water to a child with diarrhea. Two out of three thought that ORT was sufficient and only one thought that water can worsen diarrhea.

  Regarding maternal care, all women thought that a pregnant woman should make a prenatal visit, but in the majority of cases, the prenatal visit was not made due to inaccessibility (distance) of health care facilities (e.g., Dintiola) or was made late (after six months) because most women believe pregnancy should be hidden in order to better preserve it.

  When women were asked what should be done to protect a child's health, all mentioned hygiene of the body and environment (wells, latrines, etc.) and prevention of malaria using chloroquine. All put a focus on the need to have a good, well-balanced diet. Only two women mentioned immunization, probably due to the fact that the women assign this responsibility to the health agent and consider themselves to be just passive agents in this process.

  When interviewed on what the project should do to make the village health committees (VHCs) more effective in the community, the women unanimously answered provision of medicines, mainly chloroquine. Some of them added creation and equipping of primary health care structures.

  When asked about project sustainability after the project's completion date, all reported that they did not want the project to end because that would deprive them of information and training on disease prevention. In any case, they thought that the activities initiated by the project could be carried out by VHC members and animatrices provided they are given refresher training, supervision, medicines, and primary health care equipment and facilities.

- When asked about the project achievements, all mentioned the positive impact of activities on children's health. They also mentioned the provision of 100,000 CPA by the project to each village for the promotion of IGAs.

- When asked which development sectors the project should invest in if it was to continue, all responded that the same activities should go on, but some of them thought that literacy, gardening, and IGAs should be added and promoted.

B. Project Expenditures

The pipeline analysis of project expenditures is attached in Appendix 7.

USAID and World Vision Relief & Development (WVRD) have allocated $450,679 ($319,073 from USAID and $131,606 from WVRD) according to the DIP (1991-1994). Overall, the project was some $42,000 overspent (the WVRD match was increased to cover this overspending). The overspending came primarily in the personnel (salaries, benefits), travel/per diem, and other direct costs lines of the budget. The indirect costs portion of the budget was also overspent. Those areas that were underspent include procurement of supplies and equipment, and evaluation/ consultant costs.

C. Lessons Learned

The main lessons learned which are applicable to other PVO CSPs and/or relevant to USAID's support of these projects are as follows:

- It is not efficient to train community health agents and promote preventive health activities without making available services allowing them to put their skills into practice (for instance, with immunization and family planning).

- The organization of communities around cost-recovery mechanisms can be a good way to sustain project activities (village pharmacies, community gardens, mills, etc.).

- It is useful to take into account communities' time availability (e.g., rainy season) when planning project activities.

- The various partners implicated in project implementation (PVO, community, MOH, CMDT) must be involved in all phases of design, monitoring, and evaluation. This is an effective way to foster the transfer of skills at every level and help sustain project activities when the PVO leaves. The various partners should be liable to a 'protocole d'accord" determining the role assigned to each.

- It is necessary to integrate other development activities like literacy and microenterprise development with project core health activities in order to increase project impact on beneficiaries.

- It is essential to establish a form of motivation to encourage community workers in the performance of their tasks. This motivation, in kind or cash, should be determined in concert with communities.

III. PROJECT SUSTAINABILITY

A. Community Participation

During the field visits, the team members interviewed the VHC members present in each of the six villages. Usually, each VHC is

composed of five members, including the chief of the village and the president of the women's association. Added to these members are the animatrices, the matrons,. the FAA, the TBA, and the hygienist/ secouriste.

VHWs and leaders perform child survival activities such as giving IEC on nutrition, FP, vaccination, and ORT, cooking foods for malnourished children, growth monitoring, assisting women during childbirth, and distributing chloroquine. The project trained the VHC members in nutrition, communication techniques, cooking lessons, weaning practices, identifying incomplete vaccinations, and managing diarrhea1 diseases.

From the beginning of the project, VHCs were involved in planning and implementation through an open dialogue and joint planning with the project staff. During the planning phase, extensive meetings were held with community leaders to discuss village needs and the most appropriate strategies to address them.

Of the six health committees visited, five were functioning well. Members were representative of their communities. The *one* that was not working well was the committee in N'Gania, where nothing was done aside from the activities of the project workers. In this community, the choice of the committee members may not have been appropriate, even though the chief of the village was among these members. Because of social conflicts it has been very difficult for the committee members to mobilize the population around health issues.

The health committees met once a week. The most significant issues being addressed by the committees were growth monitoring, nutrition demonstrations, preparation of enriched weaning foods, and especially chloroquine distribution and preparation of ORS.

The communities contributed to encouraging the continuation of project activities after donor funding ends by:

- Building health/maternity centers.
- Covering costs of nutritional activities (women provided the food and/or money needed for preparing the weaning foods).

B. Ability and Willingness of Counterpart Institutions to Sustain Activities

As outlined in the project proposal and DIP, the project aimed for sustainability through reinforced collaboration with the following counterpart institutions or organizations: the MOH, the CMDT, the Association of Animatrices in Koutiala town ('Dembanyuman"), and last but not least the VHCs and animatrices.

As mentioned in the 'Accomplishments" section, the project has achieved sustainability at the level of the individual through lasting behavioral changes in health-related KAP, promoted through health education. At the community level, demand for health services was fostered through self-reliant VHCs. Finally, at the government level, World Vision initially supported the MOH's EPI (which explained the relatively high-55 percent-coverage rate of children completely vaccinated), and then switched to the strategy of strengthening the role of the VHCs as the main 'health enhancers" by establishing working relationships with the MOH in such a way that the MOH would be responsive to the service demands of VHCs after the end of the project.

Sustainability at the Government Level: The project provided technical and logistical support to the MOH in the implementation of

its EPI, which resulted in a good immunization coverage rate in Koutiala, but since this support ended with the change in strategy from mobile to fixed centers, the coverage rate registered a drop. Then the project focused on preventive health activities mainly designed to complement MOH health service delivery. The project mobilized the communities in regard to health promotion, promoted improved home case management of certain diseases, and fostered demand for government health services. The project mainly collaborated with the health center for training but not for supervision.

The project was highly valued by the host government institutions and beneficiaries. During an interview with the Medicin Chef (Dr. Fanta Mady Diawara), he stated that the project was very successful in mobilizing communities and in the transfer of competencies, and he agreed that World Vision made a 'great difference between the areas they covered and areas which were not covered.* The project developed a very positive reputation in terms of effectiveness. World Vision played the complementary role that was assigned to it so well that the Medicin Chef confessed that World Vision assistance is still needed at least until the 'carte sanitaire' is completed and Community Health Centers (CESCOMS) established in which activities initiated by the project can be continued.

Sustainability at the Level of the Community: The project sustainability 'machine" was built on VHCs, animatrices, and the Dembanyuman women's group, all of which definitely played an integral role in the success of the project. Unlike other CSPs (SCF-US in Kolondieba, CARE-MALI in Macina), World Vision did not use paid Family Trainers or nurse-midwives but rather focused efforts on giving training and supervision to the VHCs and VHWs in order to develop their animation skills and enhance their ability to mobilize communities and disseminate messages on healthy behaviors. There is already good evidence for the sustainability of existing VHCs in the majority of covered villages. During interviews, VHC members unanimously expressed that they will be able to 'apply what they have learned'; e.g., hygiene/wells maintenance, sanitation, nutrition, education, ORT, and malaria prevention. The role of hygiene and prevention as a health-enhancer is well understood and expressed by the saying 'Better prevent than cure' (Bana kumbe ka fisa ni bana furake ye). Again, sustainability depends on whether VHCs continue to serve as mediators between the village population and service delivery entities.

Approximately 600 volunteer animatrices (ten per village) participated in project activities. They were selected by the communities and trained by project staff in collaboration with CMDT and the MOH. They were supervised by the aide soignants and matrons once every quarter. The animatrices from Dembanyuman in Koutiala town were supervised by project staff in collaboration with the section of Social Affairs of the Division of the MOH. A serious constraint related to the lack of motivation of unpaid animatrices, TBAs, and hygienist/ secouristes which resulted in a high drop-out rate. The animatrices who dropped out were replaced. In order to maintain motivation among these animatrices, the project initiated IGAs along with the communities by providing every VHC with 100,000 CFA.

The project used a village-based Health Information System (HIS) based on a family census covering all villages. The family registers were distributed to the VHCs, and the registration was updated on a quarterly basis. The aide soignant and matrons at the rural health facilities level collected and reported information on growth monitoring, family planning, prenatal care, and ORT every month. The VHCs collected and reported on the nutritional status of children aged O-3 years and the findings of home visits every month. A computer was used to facilitate the analysis for feedback to VHWS, VHCs, and community leaders every quarter. This feedback was used to teach skills in decision making. The weakness of the system was

the lack of integration with that of the MOH, which might hinder its sustainability when the project finishes.

Collaboration With CMDT: An interview with CMDT staff revealed the following:

The project and CMDT both targeted the same objective: the improvement of the quality of life of rural women. Thus, the activities implemented by the two institutions were complementary. World Vision carried out mobilization in health, nutrition, water, and sanitation, and CMDT provided literacy training for all socio-sanitary staff (i.e., H/Ss and animatrices) and village members of VAs. Collaboration was mainly carried out in the field of post-literacy in health. CMDT also provided technical assistance in agriculture production and sold seeds to farmers while World Vision provided health training. A discrepancy in collaboration occurred at the level of seeds procurement: CMDT sold seeds to peasants while World Vision gave them free.

The collaboration could have been made more effective by reinforcing the post-literacy in health component and by drafting a 'Protocole d'Accord" regulating the terms of collaboration and the roles assigned to each partner.

The CMDT staff reported that the World Vision project fostered integration of activities and therefore provided useful assistance which had a positive impact on their own interventions. CMDT staff asserted that World Vision was the sole NGO operating in the area and that its withdrawal would be harmful to their interventions.

Collaboration With Dembanyuman Women 's Group: The project succeeded in promoting the self-reliance of this association and improving their capacity to manage their own health problems, a steady path to sustainability. The representatives of the association who were interviewed were very enthusiastic about the project. A good example of the self-reliability of this association is that, independently from the project, it designed dramas about health issues like family planning and songs about AIDS. It is likely that they will be sustainable even after the project withdraws, and if the project were to continue, it is likely that they will be used as trainers of other animatrices.

There are now two local women's associations/NGOs willing to continue activities but whose institutional capacities are not yet developed. These are CADEF, created in April 1992 and FESO (Femme Environnement Societé), created in July 1994. Their needs include training, material, equipment, and funds. They have already made contacts with the Dembanyuman association with the aim of joining efforts.

The Project's PVO/NGO Networking: World Vision participated in most activities—general meetings, training, discussion of program issues, exchanges of information and experiences, development of indicators, etc.- organized by the Child Survival Pivot Group. World Vision has benefited greatly from this forum. World Vision also actively participated in the NCP (Nutrition Communication Project) activities, in which it gained a reputation for using the best and most efficient approach, that of villager to villager.

C. Attempts to Increase Efficiency

One of the most sustainable and efficient strategies used by the project to increase productivity and cost effectiveness was the use of volunteer health workers instead of paid family trainers to promote healthy behaviors among communities. Moreover, it reduced project staff during the extension phase. The same person played the role of supervisor, trainer, and family trainer. There were three of them, each of whom covered approximately 20 villages. The

project manager supervised these three, and also acted as the driver. This strategy proved to be efficient and might be replicable in other PVO CSPs, provided the area covered by each staff member is within the limits of the mobilization capacity of one individual.

There were no expatriate staff in the project-all were Malian. The staff received training on financial management, accounting, and personnel management. The project manager, who was responsible for the project HIS, received computer training on a specific statistical software package, which improved his ability to analyze data. In spite of the heavy work assignments, the CSP staff were highly motivated, well-trained, and competent. They had adequate technical knowledge and skills to carry out their child survival responsibilities.

D. Cost-Recovery Attempts

Cost-recovery mechanisms implemented by the project included the selling of growth monitoring and vaccination cards to families. The money obtained from selling the growth monitoring cards was put into the project account in order to replace the stock by the end of the project, while the money from the sales of the vaccination cards was managed by the MOH. The recovery mechanisms would have been more developed with organizational and management training. They could generate enough money to justify the effort and funds required to implement the mechanisms. The existence of Kafo Jiginew in the region makes it an adequate setting for the development of this kind of mechanism.

The lesson learned regarding cost-recovery that might be applicable to other PVO CSPs is that it should be introduced early, right from the beginning, along with other project activities, and communities should be involved in the identification of the mechanism to be promoted and be informed and sensitized about it.

E. Household Income Generation

The project did not focus on promoting household income, but rather on community IGAs. The project initiated IGAs with the community by offering 100,000 CFA to each village for financing small projects by village animatrices (see agreement letter in Appendix 5). An agreement was signed with the village leaders, the project, and the Local Development Committee to ensure proper management of these funds.

- Forty percent of the profits were used to motivate the animatrices, not as a regular salary but as an annual reward or bonus.
- Ten percent was used to increase the revolving fund for micro-project development for health animatrices on a yearly basis.
- Fifty percent was used to support MCH activities targeting all village children aged O-6 years (purchase of products for nutrition demonstrations, supervision per diems for the aide soignant or matrone).

It is unclear to what extent the IGA system will be sustainable and efficient since it was only recently initiated (during the extension phase) and since such a system needs long-term commitment for organizational and management training to be effective.

F. Other

The aspect of sustainability in which World Vision was most successful was the transfer of competencies to VHC members and

animatrices. The project failed, however, to promote village pharmacies and facilitate improved access by communities to essential drugs. This particular activity was unplanned but could have reinforced sustainability of project activities.

IV. CONCLUSIONS

A. Strengths

- The project was located in an underserved area of Mali. World Vision was the sole competent PVO operating in the Cercle of Koutiala.
- World Vision implemented its project following the guidelines indicated in the 'Politique Sectorielle de Developpement de la Santé au Mali.'
- World Vision succeeded in the social mobilization of communities. It used a competent staff committed to the objectives targeted by the project.
- The project was staffed entirely by Malian nationals, in line with the USAID requirement of development of local competencies.
- The adoption of the strategy of training and using VHCs and animatrices proved effective and sustainable.
- World Vision took advantage of and built on existing traditional structures and implicated social leaders in the whole process.
- Collaboration with and support of the MOH and other partners was strong.
- The implementation of health activities resulted in a positive impact on maternal and child health. The evaluation team perceived a decrease in childhood morbidity and mortality, a decrease in maternal mortality during childbirth, and an improvement of hygiene in the village in general, particularly around wells.

B. Weaknesses

- World Vision has not achieved a complete integration of some activities into the program-i-e., family planning and IGAs-in spite of the existence of structures. For instance, post-literacy could have been better developed to sustain core project health activities.
- The project intervention area was too wide for the level of staff used.
- The mechanism for monitoring the VHCs' activities was not well-developed. World Vision is leaving behind some trained VHCs members, animatrices, and TBAs with, in some cases, no structure, equipment, or material required to be operational-a kind of 'chef d'oeuvre en peril.'
- The HIS developed by World Vision has not been integrated with that of the health center, which compromises its sustainability.
- The project lacks a sustainable cost-recovery mechanism facilitating access to service delivery. Village pharmacies could have provided the foundation for this mechanism.

- The termination of the project, unexpected by some principal counterparts like CMDT, is contrary to the local USAID mission's long-term commitment strategy.

C. Recommendations

Given that World Vision a) is the only PVO operating in the Cercle of Koutiala and b) has covered only two arrondissements out of six, and given the positive impact that resulted from the activities of the project on the health of mothers and children, the evaluation team recommends that World Vision commit to initiating long-term development of the remaining four arrondissements and reinforcing activities in the previously covered ones (minimum five years).

Specific Recommendations

World Vision should:

- Establish a sustainable system of supervision of activities carried out by communities in order to preserve the project's achievements.
- Reinforce the integration of health activities with other activities (literacy, IGA) for increased impact.
- Reinforce collaboration with partner technical institutions towards a more effective development of their institutional capacities by drafting a "Protocole d'Accord" regulating the terms of collaboration and stating the roles assigned to each partner.
- Focus on the development of the operational capacities and facilities of VHCs and communities by organizing them around adequate structures (i.e., community health centers, village pharmacies, etc.)
- Better promote IGAs and small-scale credit schemes and use them as instruments for supporting the project's core health activities.
- Better promote and/or develop educational materials principally in local languages.
- Develop a better system of monitoring and evaluating field activities.
- Integrate the project HIS with that of the health center to make it more sustainable.
- Establish a sustainable and feasible cost-recovery mechanism in each village, facilitating access to service delivery.

5.8 Use of Central Funding

The project receives ongoing administrative and technical support from the WV national office in Ghana, the West Africa Subregional Office in Dakar, and World Vision Relief and Development (WVRD) offices in Monrovia (CA) and Washington D.C. World Vision provides matching funds (26 percent of the total project budget) from private contributions; provides assistance with the preparation and submission to USAID of financial and narrative reports; provides feedback on such reports and assistance with technical, financial, and/or legal issues; arranges periodic auditing of project accounts; regularly provides technical materials and information; identifies and prepares contracts for consultants; and provides training (in baseline survey methodology, USAID grant compliance, management, human resource development, and finance).

The assistance seems to have been useful and appropriate in terms of frequency and the needs of the staff. The primary difficulty in guaranteeing timely support has been the lack of a regular, reliable means of communication between the support offices and the project. While the office is equipped with phone, fax, and telex facilities, none can be counted on consistently. Courier is the most reliable means of communication.

Central funding from USAID provided for administrative monitoring and technical support of the project, as described above, includes $74,207 in indirect costs and an additional $375,793 from the grant to headquarters. As of November 30, 1994, $36,999 of the indirect costs and $175,209 of the headquarters grant had been spent. See Appendix 3 for Headquarters and WVRD/Nigeria pipeline analyses.

5.9 PVO's Use of Technical Support

The types of external technical assistance received to date by the project through consultant visits, workshops, and conferences are as follows:

Consultant Visits/Training

a. Training in WHO/EPI 30 cluster sample survey methodology (Nov. 1993)
b. Monitoring/evaluation training for senior and junior staff (Feb./April 1993)
c. Computer training for HIS Coordinator and Accountant (Feb.-April 1993)
d. Family planning training for one PHN (May 1993)
e. Food consumption and nutrition survey (July 1993)
f. Analysis of ten composite dishes for energy, protein, and mineral content

Workshops, Conferences, and Seminars

a. Finance and operations workshop (Feb. 1993); 5 days
b. Community health conference (Feb. 1993); 5 days
c. Sterilization and immunization techniques (July 1993); 1 day

Appendix 1

Objectives and terms of references of the final evaluation

OBJECTIVES AND TERMS OF REFERENCES OF THE FINAL EVALUATION

Le Projet Survie de l'enfant a eu deux phases, une premiere d'Octobre 1987 a Septembre 1991, et une seconde d'Octobre **1991** à Septembre 1994. La premiere phase a eu une evaluation à mi parcours et une evaluation finale. La présente phase a eu son evaluation a mi parcours en Septembre 1993.

I. Le but de cette tvaluation finale est de:

1) Evaluer Ies objectifs Optrationnels et d'impacts accomplis par le projet.

2) Evaluer la participation communautaire et les facteurs de continuite mis en place par le projet.

3) Identifier chez les partenaires (CS+CMDT) les ressources qu'ils mettront en oeuvre dans la continuite des activites du projet.

4) Evaluer chez les bénéficiaires (meres, CSV...) du projet les indicateurs qualificatifs d'impact.

II. Les Objectifs Spécifiques:

1) Réaliser une enquête visant a mesurer les indicateurs necessaires pour apprecier tous les objectifs du projet.

2) Faire une analyse comparative des données dans le temps.

3) Apprecier les facteurs extemes et leurs impacts sur le projet.

4) Faire une analyse des facteurs de continuite des activites du projet.

5) Identifier et apprecier les disponibilites des partenaires à soutenir les activites du projet.

6) M&surer et **analyser** auprès des bénéficiaires du projet les indicateurs qualitatifs d'impact.

7) Satisfaire à toutes les exigences de l'USAID dtfinis à cet effet dans le guide d'évaluation finale.

Appendix 2

Schedule of activities

SCHEDULE OF ACTIVITIES

August 17th: - Meeting of evaluation team with World Vision Coordinator of Koutiala and world Vision Director in Bamako.

- Travel from Bamako to Koutiala

August 18th - Meeting of Evaluation team with Project staff in Koutiala to design the schedule of activities, the methodology, the survey instruments, and to divide tasks among participants.

- Meeting with local authorities

August 19th - Field visits
- Briefing of the visits

August 20th - Field visits
- Briefing of the visits

August 21th - Field visits
- briefing of the visits

August 22th - Work day with the counterparts
- Individual work of team members

August 23th - Putting together the findings
- Briefing with the project staff on the findings

August 24th - Return to Bamako

August 24th
toSept 8th Drafting of the report
. Submission of the 1st draft.